CERTIFICATE AUTHORIZING
RELEASE OF UNEMPLOYMENT INFORMATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY REQUESTOR)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PART II (COMPLETED BY EMPLOYEE)

I, _____, understand that the information in my unemployment compensation file(s) is confidential under 26 M.R.S.A. §1082(7), of the Maine Revised Statutes. However, I waive my right to confidentiality and authorize the Department of Labor to obtain and release that information, pertaining to the benefit year ending ____/____/____, or calendar period from _____ through _____ to the following:

Name: _____

Title: _____

Address: _____

_____

I understand that I may also request a copy of this information be sent to me. A copy of this waiver/consent is acceptable. **The completed form should be faxed directly to the Department of Labor, Bureau of Unemployment Compensation at 207-287-2305.**

Signature:_____ Date:_____

PART III (COMPLETED BY THE BUREAU OF UNEMPLOYMENT COMPENSATION)

Unemployment information sent to the requestor on _____.

Signature:_____ Date:_____

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.